

# First Steps PAG Meeting Minutes

**Date:** 4/29/08

**Location:** DOH, Kent, Conference RM 1

**Attendees:** Diane Bailey, Annette Barfield, Frank Busichio, Lisa Campbell-John, Karla Cain, Kathy Chapman, Janice Crayk, Cynthia Huskey, Karen Jacobsen, Susan Laabs, Maureen Lally, Kathi LLOYd, Suzanne Plemmons, Nancy Anderson

**Not present:** Sandy Owen, Nita Lynn, Rebecca Peters

Time	Agenda Item	Presenter	Purpose/Expected Outcomes	Discussion/Decisions	For Action
10:30	Welcome and review agenda	Cynthia Huskey	Review agenda	Reviewed agenda – Jan alerted PAG members about request for volunteers to serve on selected governor appointed boards – info available for them to read.	
	MSS Proposal	Cynthia Huskey	Share MSS proposal to improve prenatal care access and reach the highest risk women	<p>Cynthia shared MSS clinical team proposal for improving access to prenatal care and how MSS can better reach the highest risk women. Recommendations were based on FS provider input, current literature, and other state models and will need further work.</p> <p><b>PAG Comments:</b></p> <ul style="list-style-type: none"> <li>Need to explore Pregnancy to Employment barriers - Not only does it appear there are not incentives for women, the following are <b>disincentives:</b> <ul style="list-style-type: none"> <li>Amount of paperwork with the pregnancy to work program</li> <li>Women are then tracked in the system who don’t want to be</li> <li>Clients have mentioned they have been “put down” by workers if they disclose they are pregnant again</li> </ul> </li> <li>Yakima has placed MSS staff photos in Peds/OB offices so they remember MSS services.</li> <li>Staff burnout is an issue when focusing just on high risk clients. Staff get an emotional benefit from having some low risk clients, who are actually engaged in hearing the health messages.</li> <li>YFWC developed system to promote care coordination at a cost of \$125,000/yr. Incentives and one stop shopping seems to be engaging TANF women in Yakima. Highlights:               <ul style="list-style-type: none"> <li>During first trimester-appt. with LPN who documents patient OB history, offers First Steps and WIC</li> <li>If client accepts all services, eligible for car seat and 2 cases of</li> </ul> </li> </ul>	<p>Kathy Chapman asked PAG members to think about:</p> <ol style="list-style-type: none"> <li>How can we best engage women who are feeling overwhelmed?</li> <li>How can we best provide care coordination with substance abuse, mental health and CPS partners?</li> </ol>

			<p>diapers; one at 1<sup>st</sup> visit and 2<sup>nd</sup> at discharge and summary visit</p> <ul style="list-style-type: none"><li>○ Not allowed more than 3 no shows</li><li>○ Had a 40-60% acceptance rate in the first year - goal is 75%. They do a follow-up phone survey to find out why clients didn't accept the services. Usual reasons - no stable place to live, working full-time, no time, too busy, or just not interested.</li></ul> <ul style="list-style-type: none"><li>• Answers shared that care coordination is most time consuming for pregnant clients in jails. The jail is not referring clients until third trimester unless extremely high risk because of the cost. Staff have begun some work with care coordination at the state level. Part of a pilot will be to get a better sense of what it takes to support and implement care coordination in the program.</li><li>• Snohomish shared that their health officer put all programs under the context of early learning</li></ul> <p><b>Questions:</b></p> <p><b>Q:</b> NFP- Is there a way to collect data on access to prenatal care for NFP clients compared to FS only clients?</p> <p><b>A:</b> Not that we are aware of at the state level. A lot of the clients that are in NFP are also in FS so there is a lot of overlap. There is no code that separates out NFP clients from the general Medicaid population.</p> <p><b>Q:</b> Does the research support 1<sup>st</sup> trimester care?</p> <p><b>A:</b> Yes. There has been some controversy regarding 1<sup>st</sup> trimester care, but basically everyone agrees that getting women into care early helps with early screening and assessment of medical issues. Indiana's model utilizes multiple strategies for getting women into prenatal care early. The concern is not those women who get into care right after 14 weeks, but those who are not getting in until late 2<sup>nd</sup> trimester.</p> <p>YVFW – If a client comes in at 16 weeks with no prenatal care, they are sent straight to prenatal care, rather than following the protocol above</p> <p><b>What are next steps?</b> Recommendations will need to be flushed out more. The state wants to involve providers in the development of specific recommendations (e.g., risk factors).</p>	<p>Nancy to assist Karla in discussing client needs in jail, potentially contacting DOC medical officer.</p> <p>HRSA can offer T.A. in terms of asking the health plans to get their clinicians involved re: care coordination efforts</p> <p>It may be beneficial for FS to integrate early learning into the MSS logic model. Frank will send the "State of the LHJ" report to Cynthia.</p> <p>To consider: One of the NFP sites could ask the consortium if there is a way for them to report on data they are collecting that their not currently reporting on – like early prenatal entry rates.</p> <p>Lisa will send the logic models and other pertinent documents from the First Steps Plus pilot to Cynthia.</p> <p>State staff cannot attend provider meetings statewide, but if there are specific/special meetings where it would be beneficial to present this information, please let us know.</p>
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	Medicaid Eligibility Quality Control Proposal	Nancy Anderson	Share ideas regarding eligibility enrollment and gather provider input	<p>Nancy asked the PAG if it would be beneficial for Medicaid to conduct a statewide quality control study looking at the timeframe between the dates of application and when a woman gets services. They can do a phone survey sample of FS clients (could even single out 2<sup>nd</sup> trimester entry clients) regarding prenatal care access related to Medicaid eligibility. Medicaid Eligibility would have a set of questions they would ask, but are willing to ask other questions suggested by the FS program.</p> <p><b>Things to think about:</b></p> <ul style="list-style-type: none"> <li>• We would have no control on when the survey is conducted</li> <li>• We may end up with more information than what we want</li> <li>• It can take a long time to see a final report, however a draft can be available fairly early</li> <li>• The Eligibility Unit is not under Nancy's supervision and has their own guidelines</li> <li>• There is the possibility that clients could lose eligibility if it is determined that they are not eligible for services</li> <li>• There may be limitations about comparing data</li> </ul> <p><b>PAG Input:</b> This is a wonderful idea. The program currently has no way of obtaining client input and this would be one opportunity to obtain their input.</p> <p><b>Questions:</b> Q: What types of questions can we ask? A: Did you need help filling out forms? Did you get any help? Did you use WithinReach? Do you have a computer? How long did it take for you to chose a health plan?</p> <p>Q: Could this review be part of QA component for Medicaid admin match? If so it may support the reason for having such a review A: Nancy to think about this idea further.</p>	<p>To PAG: If you had a chance to talk to a group of clients, what questions would you like to ask about barriers to care/eligibility?</p> <p>Cynthia to email PAG members the above question and compile results for Nancy Anderson.</p> <p>Nancy to think about this idea further.</p>
	ICM	Maureen Lally	Discuss when in ICM it would be appropriate to see the mother without the infant present	<p>Mo asked input from the group about the necessity of requiring the baby be present during an ICM visit. Several members agreed the infant case manager should see the baby during the visit. Input was then requested for situations in which it would be reasonable to reimburse ICM visits with the parent without the infant present.</p>	<p><b>PAG members:</b> Please provide any further thoughts to Maureen Lally at 360-725-1655 or <a href="mailto:LALLYMA@dshs.wa.gov">LALLYMA@dshs.wa.gov</a>.</p>

				<p><b>PAG Examples:</b></p> <ul style="list-style-type: none"><li>• Childcare – child at day care and it is the only time the parent can be seen; would become a concern if it happened repeatedly</li><li>• CPS – worker may write in client plan that she must keep FS appointments, even though baby has temporarily been removed</li><li>• Shared custody - child is with the other parent; mother may not tell provider ahead of scheduled visit baby is with the father</li><li>• Baby in the hospital – visit with mother but not in the same room as the baby</li><li>• Baby is home and grandparent is caring for infant</li><li>• CPS involvement – Linkage and referral is done</li></ul> <p>FS staff should always try to make visits with the child present but there are times it is not always possible. It is frustrating for providers when services are provided, but they are unable to be reimbursed because the infant was not present. Some providers feel it is an ethical dilemma to cut off the family abruptly because the baby has been removed.</p> <p>PAG members reminded Mo that FS agencies used to be able to bill and would get reimbursed a lesser fee one time per three months for a client no show. It was not a lot of money, but at least it helped with the cost of gas.</p> <p>It is hard to switch roles from MSS to ICM. YVFWC has a specific infant case manager that isn't an MSS staff for this very reason.</p> <p>We should keep in mind that in some cultures the linkage and referral is with the family. In some cultures the grandparents are very involved in taking care of the babies.</p>	
	Counselor Credentialing	State Team- Rebecca Peters sick	Share summary of new legislation related to credentialing and possible impact on MSS BHS position	<p>Legislative Bill 2SHB 2674: Going into affect 2009 (see handout).</p> <p><b>Question:</b> Will there be distribution lists for all disciplines? A: Currently there is an RD listserv. Other listservs will be started as time allows. State staff time is in great demand currently with monitoring, clinical project and program documentation QI.</p>	<p>PAG members: please send questions/comments to Rebecca Peters at (360)236-3532 or <a href="mailto:Rebecca.peters@doh.wa.gov">Rebecca.peters@doh.wa.gov</a>.</p> <p>Distribution lists – state will keep PAG posted on further plans</p>

	Local and State Updates	All	Updates and announcements	<p><b>Local:</b></p> <p><b>Snohomish HD:</b> Snohomish HD: Have had problems recruiting nurses, this is the first time this has been an issue in their FS program. So they have formed a recruitment committee. They had considered hiring non-BSN, but then decided against it. They are recruiting through the internet, nursing schools and word of mouth. But, it’s difficult. They used to require 3 years of experience before allowing a nurse to do HVs, but now they are hiring straight out of school</p> <p>Frank also shared he attended a great conference on African American families and the role of fathers. This presentation was focused on the healthy marriages/families initiative. Frank asked how FS can involve fathers more. The PAG group agreed we need to look at this issue</p> <p><b>Spokane- Family Home Care:</b> Spokane Health District began their NFP program. There has been some discussion about Native Health beginning FS.</p> <p>A conference entitled “Our Kids, Our Business” was held in Spokane this month. Dr. Robert Anda from CDC spoke about the effects of childhood trauma and how those kids impact our health care system.</p> <p><b>Pierce- Answers:</b> They are looking to hire a BSN lactation consultant who is Spanish bilingual. Can we look at trainings for ICM staff?</p> <p><b>State:</b></p> <p><b>Jan Crayk</b> reviewed program change from using county leads to using a state directory. Distributed handouts.</p> <p><b>Nancy Anderson:</b> There is no new money available, so we are highly encouraged to be creative with the money we have. We have been told we’re headed for a shortfall. We need to look at improving the program and making changes that will help us reach the high risk women; possibly there would be fewer requirements for low risk clients, maybe just delivering health messages, or for ICM there may be fewer units available to bill overall, but providers could use them whenever they wanted.</p> <p><b>Cynthia Huskey</b> -PAG members wanted to continue serving for an additional</p>	<p>Frank to send the name of the person who spoke on involving African American fathers to Cynthia.</p> <p>Maureen Lally to look into training opportunities for ICM staff.</p> <p>County lead changes – please send back questions/comments to Jan Crayk by the end of May.</p>
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2:30	Adjourn				

**Next Meeting:** July 17, 2008

**Location:** DOH Kent Conference RM 1